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ABSTRACT

This forum considers preventive health care to include not only good physical and dental care, good nutrition, and good sanitation, but also adequate housing, quality education, sufficient clothing as well as opportunities to experience love, achieve self respect, participate in play and become meaningfully involved with others. Several population groups in our country are subject to unusual health hazards and have particular need for health care. Poor children, expectant mothers, young infants, handicapped and emotionally disturbed children, and children of migrant workers are the especially vulnerable groups. The social pathology of narcotic addiction, prejudice, understimulation, violence, and indifference to human needs constitutes other pressing problems that threaten the quality of physical and emotional health in our society. A high priority should be set on the development and delivery of needed services to insure immediate access to decent care for the most vulnerable groups. Other recommendations call for acceptance of national standards for preventive health services, manpower augmentation, research in the health sciences, adequate income, good nutrition, improved housing, and a reinstitutionalization reconstruction of the systems for delivering human services as a national commitment. (WY)

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KEEPING CHILDREN HEALTHY:
HEALTH PROTECTION AND DISEASE PREVENTION

Report of Forum 10

1970 White House Conference on Children

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SUMMARY

The United States has long offered Americans the opportunity to confront and master new frontiers. But, although we have accomplished much in some areas, constructive health services and disease prevention still offer unlimited challenges and areas for great achievement. It has been clearly demonstrated that such services reduce the prevalence of illness and enhance the quality of life: they must now be implemented on a broader basis.

This forum considers preventive health care to include, in addition to good physical and dental care, adequate housing, quality education, sufficient clothing, good nutrition, good sanitation, as well as opportunities to experience love, achieve self-respect, participate in play, and become meaningfully involved with others.

Several population groups in this country, currently subject to unusual health hazards, offer special opportunities for constructive health care. Poor children, for example, experience more preventable deaths and permanently handicapping conditions than any other group. Indeed, poverty is the most important cause of poor health in children and youth in this country. Other especially vulnerable groups include expectant mothers, young infants, handicapped and emotionally disturbed children, and children of migrant workers.

Social pathology is a major cause of death and disability among our young children. Narcotic addiction, prejudice, understimulation, violence, and indifference to human needs are major problems which threaten our very society.

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If we accept the principle that health is a right of every person and not a privilege, we must give the development of the needed services a high priority. Urgent attention must also be given to the considerable inequities in the delivery of human services. Those with the greatest needs should not be asked to wait for a national health program -- they deserve immediate access to decent care.

The recommendations of this forum, which presuppose a national commitment to the intrinsic value of children, call for national standards for preventive health services, manpower augmentation, research in the health sciences, adequate income, good nutrition, improved housing, and a reconstruction of the systems for delivering human services.

FORUM 10*

KEEPING CHILDREN HEALTHY:

HEALTH PROTECTION AND DISEASE PREVENTION

Although the exigencies of time and space do not permit their contributions to be specifically identified, I am indebted to the many gifted people from a wide spectrum of backgrounds who have been co-authors of this report. Their creative ideas expressed to me verbally or in writing have been used freely and often verbatim in the preparation of this manuscript. As their grateful, admiring editor I have not attempted to rewrite their authoritative statements nor re-express their eloquence.

Since this report has not yet been reviewed by anyone else on the Forum, I assume all responsibility for its present content.

Morris Green, M. D.

Preliminary Draft
October 15, 1970

*At the request of the Chairman, this has not been edited

October 15, 1970
Preliminary Draft

FORUM 10

KEEPING CHILDREN HEALTHY:

HEALTH PROTECTION AND DISEASE PREVENTION

I. The Current Scene: Problems, Accomplishments, Goals

A. Poverty

Poverty is the most important cause of poor health of children and youth in this country. Twenty percent of the population lives in poverty and millions of poor children are needlessly subjected to ill health and unfulfilled development.

Poor children receive less health care than those in economically more favored circumstances. They experience more preventable deaths and permanently handicapping conditions. The chance of a poor child being born with low birth weight is two or three times that of the white middle class child, and he is twice as likely to die before his first birthday. Approximately one out of three Indian babies in the United States die between the ages of one month and one year, largely from preventable diseases, and those that survive have a life expectancy of but 43 years.

Poverty is associated with poor housing, crowding, unemployment, limited education, malnutrition, bad sanitation and a sense of being left out; an increase in prematurity, infant mortality, tuberculosis, venereal disease, hepatitis, nutritional anemia and rat bites. It is tragic that today in this affluent and technically-advanced country Indian children suffer from typhoid, dysentery, tuberculosis, hepatitis, diphtheria, and trachoma.

B. Health Services for Vulnerable Groups

1. Problems

While the White House Conference on Children must address itself

to all children in the country, a number of population groups in this country are subject to unusual health hazards and offer a special opportunity for constructive health services.

a. Expectant Mothers

Prenatal, delivery and postpartum services are not available to approximately 600,000 women in the very low economic groups. Between one-fourth and one-half of women in low income families in large cities deliver with little or no prenatal care. In some inner city census tracts and in some rural areas the percentage is even higher.

In part because of inadequate maternal and infant care, including family planning services, the infant mortality rates and rates of prematurity are twice as high among the poor as among the middle class. The low-birth-weight babies, born to this group in disproportionly large numbers, are much more likely to experience permanent neurologic disorders such as cerebral palsy or mental retardation. Inadequate maternal care also leads to high rates of illness among infants and children born to such mothers and an excessive number of serious maternal complications of pregnancy.

The nature of these complications, the brief period available to the obstetrician to modify their unfavorable influence on the outcome of pregnancy and the large proportion of low birth infants born to this group of women has underlined the necessity to provide interconceptional care so that the next pregnancy may have a more favorable outcome. Such preventive services would include management of maternal anemia, diabetes, chronic nephritis, malnutrition, pyelonephritis and toxemia;

early detection of maternal-infant blood group compatabilities and maternal syphilis; and provision of educational, nutritional and mental health services.

Prevention of prematurity is an urgent goal. More than any other one factor, a decrease in premature births would result in a marked decrease in infant mortality and in the neurologic sequelae of prematurity. The prevention of prematurity involves, however, not only purely medical considerations but, even more importantly, attention to social and economic causes. The rate of prematurity, for example, is two times greater in out-of-wedlock pregnancies.

b. Infants

In terms of infant mortality, the United States ranks fourteenth internationally. This unacceptable situation reflects many problems besides that of the health of the baby, chiefly many inadequacies in human services. While it is encouraging to report that infant mortality is decreasing in this country, the rate of low-birth-weight infants is increasing.

With approximately 60% of the deaths of infants occurring within the first two days, 15% in the remaining 25 days and 25% during the rest of the first year of life, there is obviously an urgent need for more adequate health care services during the first year of life, especially in the perinatal and neonatal periods.

The ability of many mothers to provide adequate maternal care is seriously hampered either by their past life experiences or contemporary stresses. Such mothers, at high-risk for social

and psychologic reasons, may have infants who do not thrive physically, socially, emotionally or cognitively. Pathogenic life experiences may include the history of a poor relationship with her own mother, a previous or on-going emotional illness, unresolved grief, marital discord, medical illness, a number of children in quick succession, an out-of-wedlock pregnancy, illness in the family or multiple moves during the pregnancy; contemporary events that may undermine the mother's ability to provide adequately for her baby include the birth of a premature infant, the presence of a congenital defect in the infant, an early critical illness in the infant, maternal depression, a difficult delivery, psychological or physical absence of the husband, social isolation, financial insecurity or multiple births.

Needless separation of the infant from his mother due to hospitalization of either or for other reasons may produce a special risk factor for the infant and young child.

Although immunizing agents are available to prevent much infectious disease, a significant percentage of the nation's children are not adequately immunized.

c. Children and Youth

About 12 million children are estimated to need special care for eye conditions, over 3 million children need treatment for speech impediments and over 2 million have orthopedic handicaps. Many of the health needs of these and other children are not being met because of inadequate preventive, diagnostic and treatment services in low income areas, particularly in major cities. In many large outpatient depart-

ments, children are waiting five to seven hours to be seen hurriedly by a physician.

When the needs of children are discovered through school health examinations and screening programs, community agencies do not have the resources to provide treatment and follow-up care. There is a marked lack of opportunities for the children to be enrolled in systems of continuing health supervision rather than the episodic kind of care characteristic of children who live in low income areas.

d. Pregnant Adolescent Girls

Pregnancy in adolescent girls, the chief reason for girls leaving school, has been singled out for special attention in recent years by a number of organizations. The increasing number of pregnancies among adolescent girls and the decreasing age at which girls become pregnant jeopardizes not only their own health but that of their infants e.g., the infant mortality rate increases when the maternal age is less than fifteen years. Unless there is effective intervention, these girls will have many more unwanted pregnancies, and many of them will become dependent upon public assistance.

e. Adolescents

Health problems in this age group include those of drugs, venereal disease, smoking, and adolescent parenthood. Many are poorly nourished and poorly prepared biologically to become parents. The adolescent parent, the child with a child, frequently has his or her own developmental tasks to accomplish and is not prepared to nurture the development of an infant or young child.

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Suicide, school underachievement and school drop-outs present other problems for this age group. Delinquency, an extremely complex and urgent problem, has no simple solution. Vocational programs and guidance are generally unavailable for adolescents who are either not equipped to pursue an academic program or who do not choose to do so. Adolescents who are retarded or otherwise handicapped lack recreational opportunities.

f. Dental Care

There is wide-spread poor dental health. Only about 15% of the country's nearly 1600 local health units have dental health programs staffed by dentists or dental hygienists. The special needs of low income children are illustrated by the finding that 75% of children in families with an annual income of less than $2,000 and 66% in the families earning less than $4,000 have never been to the dentist.

The most prevalent chronic diseases in the United States today are oral diseases. Almost no one escapes these diseases during his lifetime. The onset may begin early in childhood, and, if neglected, result in the conspicous deterioration of oral health found in the adult population. It is paradoxical that these needlessly devastating conditions should be permitted to continue when the requirements for their prevention and amelioration have been determined and a positive, clear-cut course of action is available for application.

g. Handicapped Children

Countries in Western Europe have high developed services for handicapped children. The outstanding dissimilarity

between the United States and the European nations is the degree of national commitment to services for handicapped children. Whether based on self-interest alone, or compassion, a sense of national obligation at least equal to that in the European countries is a prerequisite to any broad advancement in services for handicapped children in this country. This Forum doubts whether we yet meet that prerequisite.

While another Forum is directly concerned with the handicapped child, this Forum is concerned with the prevention of additional handicaps in these children. Confronted frequently with serious emotional disorders in handicapped children and their families, many professionals have been troubled by the thought that some secondary handicaps in these children, traceable to psychologic and social factors, might have been prevented. On the premise that such families and children constitute a population at special risk, there has been considerable interest in emphasizing prevention as well as treatment in programs for handicapped children. The impetus towards such preventive intervention is based on the following kinds of observations:

1. Parents of handicapped children often feel markedly inadequate.
2. Child-rearing practices are frequently distorted, owing to parental depression, anxiety and other factors.
3. Lack of communication within the family is a striking defect.
4. The family may become socially isolated.
5. The family may postpone or avoid seeking help.

6. The family's finances may be severely strained.

7. The child may have a low self-esteem.

h. Family Planning

Family planning may be helpful in the optimal spacing of children for biologic as well as psychologic and social growth and development. While there is a proven relationship between the interval between pregnancies and neonatal mortality, the significance for child rearing practices of children born in quick succession is not yet well understood. It is important that unwanted pregnancies among unmarried girls be significantly reduced since infants born under these circumstances are high risk.

i. Migrant Workers

The children of migrant workers represent a large population with unmet health needs.

2. Accomplishments

A number of important national maternal and child health programs have been developed in recent years to combat some of the deficiencies noted above in health services for children. It seems appropriate to report some of their many impressive achievements.

a. There has been a significant reduction of infant mortality in urban ghettos. In the past three years, the nation's infant mortality has decreased more than twice as much as in the decade from 1956 to 1965. Larger reductions occurred in the major cities than were observed nationally. The maternity and infant care programs in many of these large cities are making a major contribution to these reductions.

b. Comprehensive health services have been delivered to pregnant women and to children in low income areas which have few medical practitioners.

c. In implementing the national policy to make family planning services available to women of low income who want these services, 425,000 women received family planning services in 1968.

d. Medical care of high quality was provided last year for 425,000 children who are crippled or who have conditions which may lead to crippling. This includes, for example, care for over 30,000 children born with congenital heart disease, many of whom were cured or greatly helped through open heart surgery.

e. Specialized diagnostic, evaluation and treatment services were provided 45,000 mentally retarded children in 150 clinics in 1968.

f. More than 100 special programs for unmarried pregnant girls of high school age have been initiated and are demonstrating that a reduction of perhaps 60% can be made in repeated out-of-wedlock pregnancies. There has also been a major break-through in community attitudes and action. In the programs for school age girls now in operation, teenage unmarried mothers are helped to complete their high school education and are provided health and counseling services.

g. The 59 new comprehensive health care projects for children and youth permit poor children to have the benefits of a preventive health care program designed to avoid the development of serious health problems. These innovative programs have also shifted the emphasis from mere survival to growth and

development. Currently over 400,000 children are registered for comprehensive care in this program.

h. The Office of Economic Opportunity and a number of voluntary organizations have developed some 55 neighborhood health centers with new and imaginative ways to reach out to people in economically deprived areas and to make services accessible and available.

i. The Head Start program has made possible enrichment programs for preschool children and has centered the nation's attention on the development of young children.

C. Social Diseases

Social pathology is a major cause of death and disease among young children. Narcotic addiction, prejudice, understimulation, violence and indifference to human needs are both major societal problems and threats. Such social diseases represent a frontier for preventive health services.

1. Prejudice

Racism is the most threatening social disease in this country.

2. Drugs

Narcotic addiction and the drug culture represent urgent preventive as well as rehabilitative problems.

3. Environmental Hazards

Because of the massive migration from rural to urban areas and from the cities to the suburbs, the relative proportion of low income families in the cities has rapidly increased. Three-fourths of the black population now live in cities. Their children are being needlessly exposed to the constant health hazards of traffic, air and water pollution, overcrowding, lack of recreation and crime. Inadequate sanitation persists in both urban and rural areas.

There has been an indifference to the environmental needs of children and thousands of children are experiencing developmental declines, especially in the cities. The depriving environments and the resultant major hazards which they present for the physical, psychological, intellectual and social development of young children may be leading to a greater wastage of human resources than any other health problem, particularly tragic because it is largely preventable.

4. Nutrition

Hunger and malnutrition exist widely in the United States. Although the data are not yet complete, undoubtedly a large number of the 27 million persons estimated to be living in poverty in this country are not financially able to purchase an adequate diet. Hunger and inadequate nutrition lead to poor physical growth, impaired ability to learn in school as well as needless discomfort and distress. Children should be experiencing hope and joy, not hunger and anxiety.

Although the clinical signs of malnutrition can be treated during pregnancy, many experts believe the long-term effects of life-long malnutrition cannot be corrected during these few months.

The prevention of obesity in adults is an important challenge.

5. The Family

The family in the United States is in trouble as evidenced by the high incidence of divorce, separation, desertion, family discord, out-of-wedlock pregnancies and what has been termed the "new" morality. Housing, adequate income, good nutrition, dignity and opportunities for jobs are basic needs. Unless a family feels secure, they are not able to plan ahead, a basic prerequisite

for the utilization of preventive health services. Families require immediate help at times of crises - death, illness, the birth of a handicapped baby, multiple births, divorce, desertion and unemployment. They need integrated services which approach the family as a whole. Programs should not discriminate against low-income intact families. Many families are socially isolated in this country, especially the one parent family but also many intact families. The family with a working mother has special child care needs.

Homemakers are not sufficiently valued in this country. The contribution that mothers or mother substitutes make to national goals needs to be more highly esteemed. Popularization of the distorted notion that children are a burden and a deterrent to the fulfillment of a woman in her own right does a great disservice to children.

Highly-qualified homemakers should be quickly provided to substitute for the mother who is psychologically or physically unable to take care of her children or who has to be absent from the home. Homemaker services have not been adequately supported in this country, among other reasons, because of fears, perhaps derived from our pioneer heritage, of making mothers lazy.

Although children in suburbia are frequently considered to be in an advantageous position, they also face many preventable problems. Little is known about the epidemiology of emotional problems in such settings. Many of these children and their mothers appear to be overscheduled. Some are taking drugs, others are involved in delinquent acts and many live in a relatively fatherless society. Children of such mobile populations as the military, academicians and corporation executives may be at some

special risk. Although it would appear that their adjustment depends upon that of their parents, insufficient studies have been done to determine whether a preventable problem exists.

With less hospitalization and earlier discharge of men and women with major psychiatric illnesses, the effects of such a parent in the home on the development of children needs more study and preventive attention.

D. Delivery of Human Services

There is a crisis in the delivery of human services, including health care, with considerable inequities among many groups: the poor and the non-poor; the inner city and surburbia; urban and rural; and black and white. Urgent attention must be given to this problem of inequity. It should not continue in a democratic society. With acceptance of the principle that health is a right of every person and not a privilege, a national commitment is needed to develop the needed services that are coordinated, comprehensive, continuous, compassionate, personalized, accessible, available, acceptable and of high quality.

The present arrangements for preventive health services are grossly underdeveloped, poorly organized and fragmented. As expressed by one Forum member, we fractionalize families to death with our helping practices. Changes in social, welfare, vocational, health, housing, and recreational and educational services will be difficult because of long-established patterns, vested interests, ineffective use of existing personnel, distorted priorities, inadequate professional training and lack of communication. Except for education, most public human services have been more remedial than preventive or constructive.

One of the most important conceptual changes in recent years has been the recognition of the importance of outreach in human services

and the awareness of the many psychologic and social impediments to obtaining health care. Services are being brought to isolated families in mobile units or patients are brought to and from the health facility by transporation services provided by the health facility. The new programs are not based on the traditional model of one patient to one physician but rather have developed the health team, a group of professional and non-professional persons.

E. Funding of Human Service Programs

There is a crisis in public administration of health programs characterized by inadequate funding, overlapping jurisdiction and categorical approaches with fragmentation. Essentials of acceptable health programs include the absence of a means test, the purchasing power to obtain health needs, resources to meet the needs, economic incentives for keeping people well, provision for presymptomatic screening and health education, remuneration for developmental services to children and families, i.e., fostering optimal growth and development, talking with school teachers or counselling a parent regarding such family crises as the impact of divorce, and an allowance for the cost of outreach services.

The adoption of a method of payment will not, in itself, increase the availability of medical services. Spending large sums of money does not insure decent care. Thus Medicaid has had little impact on the kind of medical care received by urban poor residents because of the large numbers of people and the few doctors left there to provide the care needed. It has worked out better in smaller communities where physicians are accessible. New organizational and personnel resources are required along with ways to finance them. Since at this time there is simply neither the organization nor the manpower to

provide comprehensive services for everyone, special projects and programs for mothers and children in low income groups need to be continued on an urgent basis.

F. Manpower

Preventive health services cannot be adequately implemented unless there is sufficient manpower. Much has been written about the shortage, underutilization and uneven distribution of health personnel and the need for a redefinition of roles. The time allotted to teaching and experience in family-centered, constructive and preventive health care is generally very limited in undergraduate and graduate professional education, and there are few programs designed to teach persons already in established roles how to function more efficiently and effectively. Recent medical school graduates are, however, increasingly interested in health care and of being of service to the community.

G. Protective Services

The "Declaration of the Rights of the Child" adopted by the General Assembly of the United Nations in 1959 recognizes that physically, mentally and socially handicapped children must receive the special care and training they require. The United States, no less than a developing country, has a duty to see that no child is handicapped physically, mentally or socially by an unwholesome environment whether that environment is caused by inadequate housing, morally corrupting parental conduct, gross parental neglect or abuse or by any combination of these or other factors. Where protective services to children in their own homes are unavailable or are ineffective, society must provide a substitute protective home.

The extent of the housing program needed to provide adequate homes for children in need of protection is not known. Existing child-

abuse legislation is not too helpful in estimating the extent of child abuse inasmuch as there is no uniformity as to the nature of the injuries to be reported, the persons having the duty to report, the age of the children covered or the penalty for not reporting. Very few states provide for the maintenance of central registries for the reporting of child abuse. Neither is the incidence of incest known. Records of criminal, juvenile, and paternity courts, however, as well as selected studies attest to its growing rate.

Foster care has provided neither the quantity or the quality of protection which the American child needs. As a result of this failure, many neglected, abused and dependent children, through no fault of their own, have become diseased and delinquent and ultimately have become criminal and dependent adults. Criminality and dependency are intergenerational in effect. Protective housing should be an effective weapon to break this cycle.

Children living in institutions whether orphanages, institutions for retarded or emotionally disturbed children, homes for dependent children or schools for delinquent or pre-delinquent youth, represent populations at high risk. In many ways, these are forgotten children.

H. Education

Health education services are markedly inadequate for children, for parents and for the great number of persons who provide services for children. There are too limited arrangements for answering parents' questions or for routing them to available resources.

In addition to health education, much remains to be done to provide the nation's children a better general education. Every child should have the opportunity for quality education according to his needs, whether he lives in the city or in the country, and whether he is

of normal intelligence, retarded or emotionally disturbed.

I. Neglect of Preventive Information and Services

Although preventive health services have clearly been demonstrated to reduce the prevalence of illness, and hospitalization and thus to have an economic as well as a personal value, constructive and preventive health care has had limited implementation and scope in the United States. We know more than we are putting to use. Levels of preventive care at least equal to that in other developed countries should already have been achieved. Yet it must be reported that today the infant mortality in some sections of the country could be reduced by 50%, and there could be significant decreases in visual difficulties, hearing problems, anemia and illegitimate pregnancies in adolescent girls. It is significant that the American Medical Association has identified the improvement of maternal and child health services as a central challenge for 1970.

Although the goal of good physical care is still to be realized, constructive health care is more than that: it includes the shelter, clothing, love, self-esteem, education, safe play, music, stimulating experiences and involvement with people and things needed to keep children healthy.

The immunization model of preventive health services must be complemented by other models if the full potentials of preventive services for children are to be realized. The emphasis should be on processes which underlie health. The newer knowledge of genetics, biochemistry, immunology, psychology, sociology, social psychology, cultural anthropology and child development provides opportunities to deal with the precursors of disease and the achievement of positive health. There is a need to develop a nosology of health as comprehensive

as our present nosology of disease.

Such a classification of health, or of the ground midway between health and disease, would obviously include considerations of such symptoms as shame, anger, fear, frustration, distress, disability, ineffectiveness, inadequacy, depression, helplessness and anxiety; but also such feelings as serenity, hope, joy, trust, love and happiness. Ineffectiveness applies to the mother who cannot provide adequately for her children, the child who is not doing well in school, the chronically-ill patient who feels inadequate and shunned, and the child without motivation or hope for success. Destructiveness is characterized by the use of drugs, violence and neglect of one's own health. "Happiness is..." describes the full potential of the "new" child health goals.

Preventive health sources for children should increasingly incorporate knowledge concerning the pathogenesis of diseases of adult life, e.g. the relation between diet, exercise and cardiovascular disease. Insurance companies should provide financial dividends for periodic health appraisals.

II. A Blueprint for Action Now: A Commitment to Human Services

A. Human Services With a Health Orientation

Recommendations made here for preventive and constructive health services presuppose a national commitment to the intrinsic value of children, and to the betterment of human life. They require a determination to correct the disparity between what we could do and what we are doing. Everyone should want to see adequate medical care with an emphasis on children in this country. However, in the present health crisis, everything that needs to be done cannot realistically be done overnight. While aspiring to provide comprehensive health services for all, special attention must be given now to those with the greatest needs. Poor children, handicapped children, children in remote areas

and expectant mothers should not be asked to wait for a national health program. They deserve access to decent care now.

1. Target Populations with Problems of High Priority.

a. Poverty

In recent years the national maternal and child health programs have endeavored to reduce infant mortality, especially among the poor, and to increase accessibility of health services for those in low income areas or in other areas lacking adequate services. Special emphasis should be placed on the following objectives:

1. Comprehensive Maternity and Infant Care.

Since high infant mortality rates and poor health of mothers in deprived areas constitute a major part of the health problems of the nation and since they are ameliorable through concentration of adequate resources, it is recommended that funds be used under both the existing Title V programs and new legislation enacted to support a broadened attack on them.

The maternity and infant care projects, now numbering 53, currently provide comprehensive maternity care annually for 125,000 women of low income and for their infants. Assuming that 20% of the population are poor, there are about 750,000 births annually to women in poverty. Since the maternity and infant care projects now in their fifth year have demonstrated that they are providing care of high quality, are well-received and effective in reducing the excess infant mortality among the poor, it is recommended that this program be expanded to make such services

available to all poor pregnant women.

2. Adolescent Mothers

It was estimated that approximately 80,000 girls under the age of 18 would have an illegitimate child during 1969, and that they would have a total of more than 240,000 children born out of wedlock unless they received comprehensive services, including family planning in combination with social and educational services. The girls need new models with whom they may identify so that they will continue their education and not have a second baby out of wedlock. Since this is a high risk group of maternity patients, it is urgent they receive necessary care.

Steps should be taken to eliminate all local statutes that disqualify the pregnant adolescent from continuation of schooling. Adequate support should be made available to initiate and maintain additional special school programs in conjunction with comprehensive health and social programs to insure continuity of education and necessary health care for all girls who become pregnant. Action should be initiated to develop practices, regulations, and laws which will make available family planning information and services upon request to the adolescent whether she is married or not.

3. Comprehensive Health Services for Preschool and School Age Children

A major emphasis in funding health services programs should be placed on comprehensive care for preschool

and school age children in low income areas. Increased support should be given to such services through special project grants for health of preschool and school age children. In the next five years, it should be possible to support projects serving areas in which a total of 3.5 million children live.

4. Dental Services

Because of the wide spread problem of poor dental health, a special project program is needed to permit a broad public health attack on the problem. This Forum endorses and supports the American Dental Association's proposal for a national dental program for children and the implementation of community dental programs for children.

It is also recommended that a system of remedial mobile dental units be developed in areas without permanent dental installations.

Preventive programs including fluoridation of public water supplies and substitutes for sucrose in the diet should be expanded. In largely rural states, however, only one-half of the population is served by municipal or sanitary district water supplies. School fluoridators are being used in some rural areas where the student population does not have access to fluoridated public water supplies. Supervised self-applied topical fluoride application is a relatively new measure being used in other areas in the country with success. One trained person can instruct and supervise large groups of children.

5. Family Planning Services

Such services should be extended to the approximately 5 million women of child bearing age who live in low income areas throughout the country and who would make use of family planning services if they were available.

b. Crippled Children's Services

Services for crippled children should be strengthened to intensify case finding and screening activity and to provide necessary treatment and follow-up care.

c. Emotionally Disturbed Children

The Forum endorses the Report of the Joint Commission on Mental Health of Children which emphasizes the need for comprehensive services for the mental health of children and youth.

d. Catastrophic Illness

Families should be insured against the high cost of catastrophic illness.

2. A National Commitment to Keeping Children Healthy

a. Standards for Preventive Health Services

The Department of Health, Education and Welfare should establish standards for preventive health services to be applied to every child and mother in the nation. Each state should present a plan to achieve such standards within a five year period.

Such standards should include screening tests to identify threats to normal growth and development. Screening tests would include a health history, height and weight, urinalysis, hemoglobin, vision and hearing tests, tuberculin test, immunization review, dental examination, developmental screening

and behavioral screening. In designated areas, screening for lead poisoning would also be recommended. Teachers, nurses and others who work with children would report for examination children noted to be experiencing difficulty in growth and development. Expectant mothers would be given a health history including genetic information, physical examination, urinalyses, hemoglobin, a chest x-ray, a serologic test for syphilis and studies to identify the possibility of a maternal-infant blood group incompatibility. Screening of infants for phenylketonuria would be mandatory.

Public health programs in communities and in the states should be strengthened and basic public health services expanded. Health Departments and universities could be mutually strengthened by contractual arrangements with the latter supplying the academic and research capability and the latter the operational expertise and experience in the advancement of knowledge and services in the area of preventive and constructive health care. Such funding would provide support for such personnel in the medical school as epidemiologists, anthropologists, sociologists, social psychologists, economists and management experts. With such support, university departments of pediatrics could increasingly become health as well as disease-oriented and health departments could more effectively apply advances in knowledge and continuously revitalize their program.

b. Investigation of Preventable Morbidity and Mortality: Surveillance, Evaluation and Monitoring

The citizens of this country are responsible not only for their own health and that of their children but for the health

of those who do not have access to adequate health services and who are unwittingly subjected to preventable health hazards.

Each state should be required to establish a division for preventive health investigation to identify preventable child health hazards, investigate failures to utilize preventive knowledge, seek correction of deficiencies through the exercise of appropriate authority, inform the public and governmental authorities when new legislation is needed, hold public hearings, investigate individual preventable deaths, develop standards and make periodic reports.

Under the direction of the Center for Disease Control, national, state and community surveillance of preventable morbidity and mortality should be broadened beyond that currently centered on infectious diseases. Such surveillance would permit early identification of such health problems as child abuse, lead poisoning, burns, drug use and emotional illnesses. Because of the lack of epidemiologic studies of much of the physical and psychologic morbidity in many of our communities, knowledge of the incidence and kinds of preventable problems is imprecise. Epidemiologic studies could provide the feedback needed to initiate or revise health programs.

c. Health Education

The Forum recommends that a major commitment be made to health education.

1. Family Life Education

Family life education for parents or prospective parents including information concerning child development, child care, nutrition, family relationships. home management, dental health, and mental health would enhance the growth and

development of children and make parents more self-reliant.

Essential to help reduce the incidence of pregnancy in young adolescent girls would be the inclusion in school curricula of instruction in the social and psychologic aspects of human reproduction and the importance and means of achieving responsible parenthood.

2. School Health

Health education in the schools, including attention to human development, should be upgraded if children are to acquire an informed responsibility for their own health. In larger school systems, specialized teachers could be assigned to teach health in a group of primary schools. Junior or senior high schools would have full time health teachers.

3. Resource Materials

Resource materials should be prepared for both parents and youth in a number of forms, languages and approaches to increase their knowledge of child and family development, child care and health. The potential of mass media for communicating positive health information should be more fully explored. Project support should be available for a variety of health education demonstration projects.

d. Early Case Finding

Advances that could be utilized for early case finding should be made immediately available to every child and adult in this country with financial incentives or grants to facilitate the incorporation of new procedures into the preventive health

armamentarium.

3. Manpower

a. Increase in Health Professionals

There is an urgent need to increase the supply and improve the effectiveness of personnel in maternal and child health services. Impetus can be given to the recruitment and training of pediatricians, obstetricians, child psychiatrists, nurses, social workers and psychologists by project grants to universities. One means of improving services to minority group families would be to recruit and support students from minority groups.

b. Changes in Professional Curricula

Grants should also be made to professional schools to improve the teaching of health to primary physicians, i.e., family physicians, pediatricians, obstetricians and internists, to dentists, and to allied health personnel. The traditional training of the health professionals needs reexamination so that they are more family-centered and equipped to deal adequately with the problems that patients bring to them. Their curricula should include information about the special needs, life styles and expectations of specific cultural, social, racial or economic groups.

c. New Health Personnel

New types of personnel must be recruited to augment the short supply of the traditional professions, and new methods of training must be developed for such individuals. Such new categories would include obstetrical assistants, pediatric assistants and health aides. The latter can be trained to provide specialized as well as comprehensive or generic services. They

should be recruited from the areas in which they will serve, should receive an adequate salary and be provided opportunities for advancement.

d. National Health Corps

Consideration should be given to the organization of a National Health Corps.

e. The Need for Teamwork and Rearrangement of Roles

Manpower must be used in new kinds of organizations that emphasize teamwork. In terms of pediatric care, the pediatrician will not work alone in the future but will lead a group of professionals and health aides interested in children and families. In addition to his traditional goal of achieving a working health alliance with children and parents, he will develop a working alliance with schools and other resources in his community in the service of his patients' health. Teamwork has been institutionalized in the hospital. It needs to be institutionalized in the community.

The development of subprofessionals, through a popular preoccupation now, will not solve the manpower crisis. It would seem to be useful to try to use the conventional manpower in new and imaginative ways. One way to utilize the present disciplines more effectively would be to support innovation and new work arrangements between the disciplines so that these professionals would be free to deal with the problems of the patient. This means that whoever is closest geographically to the patient in time and space when the patient presents a particular health need should be able to respond appropriately if they have the proper training without all the current

bureaucratic and legal restrictions now placed on health personnel.

It might be possible, for example, to establish a small group of nurses in the various natural communities and neighborhoods within cities as well as clusters of these nurses serving rural populations. It seems more efficient to have nurses work in small clusters of 3-5 members rather than to be in solo practice. By being in clusters, the time during which a practitioner is available to a population could be extended greatly throughout each of the 24 hours and over a 7 day period. This would mean that people would have an easier entry into the health care system, the transportation problem would be minimized especially for low income families and opportunities for health education would be increased greatly.

In this arrangement, the nurses would be in small satellite clusters attached either by closed circuit television or by direct telephone lines to the pediatrician's office, a general hospital, a medical center, or a combination of any of these. The use of closed circuit television would enable the nurses to present on the screen either the patient or any of the data assembled about the patient so that the pediatrician would be in instant consultation with the nurses.

The primary role of these nurses would be in health maintenance and illness prevention rather than in disease management, even though the nurse may be reasonably well-equipped to manage a substantial portion of these entities. Since many of the incipient causes of poor health in children come from inadequate prenatal care, it might be beneficial to develop a substantial

cadre of nurse-widwives trained at the graduate level. These nurse-midwives could function in clusters similar to that described above, especially in lower income and poverty populations.

One means whereby nursing competency might be used is to expand the role of nurses such as now is being done in a number of graduate programs in university schools of nursing. The development of the family nurse practitioner would readily make available a skilled person and would extend considerably the ability of physicians to deal with the highly complex problems of the population they service. Graduate schools need to be supported in developing this type of practitioner and ways must be found to enable this type of nurse to serve the populations at risk.

4. Research

Preventive approaches are optimally based on an understanding of the etiology of the problems one is attempting to prevent. While much remains to be done in terms of the application of information we already have, for many disorders affecting thousands of children, there are no effective preventive measures. We do not know all the answers. The path to prevention in these instances begins with research. Such unsolved problems in child health include prematurity, low-birth-weight infants, sudden death syndrome of infants, malignancies, allergy, cystic fibrosis, birth defects, mental retardation, immunologic disorders and emotional diseases.

Support should be given to development of model perinatal centers in several sections of the country in an attempt to improve the survival of babies prematurely born, of small birth weight or with other disorders.

Maternal and childhood research centers should be established in both urban and rural areas to study health service delivery, innovative models of providing care and training of new kinds of personnel.

B. Services Based on Developmental Needs of Children and on the Developmental Processes Concerned in Constructive Health Services

Since this nation cannot in the next several years meet the health needs of the entire population and since priorities must be set, this Forum asks that a high priority be assigned to children and youth for immediately available health services. Children have special vulnerabilities because they are developing and growing rapidly. What happens to their development early in life determines to a large extent their social, vocational, physical and emotional competence as adults. Children also represent the best investment for preventive health services, the most economical type of care in terms of effectiveness.

The section below discusses preventive health services in terms of the developmental needs of children at different stages of their life process. The development of a relationship between the provider and the consumer of health services is important in long-term illness; it is equally important in the achievement of long-term health. Truly constructive health services require a continuity and a growing relationship that permits the consumer to utilize comfortably and fully his opportunities for health.

1. The Child and His Family

Preventive health services require attention to the family as a unit.

a. Income

Every family in the nation should be guaranteed an annual

income sufficient to meet their basic needs; however, the provision of such an income should not, in itself, be expected to guarantee personal health care.

b. Nutrition

This Forum endorses the recommendations of the White House Conference on Nutrition, including the urgent need to make available nutritious food in adequate quantity to every family in this country. The Food and Drug Administration should vigorously enforce existing standards for nutritive value of foods. Existing food programs should be expanded and improved to eliminate hunger.

c. Housing

Adequate housing is a basic necessity of life and a prerequisite for keeping children healthy.

d. Dignity

Optimal health requires respect for the dignity of each child and his family.

e. Family Crises

Emergency services should be made available to families in crisis. A high priority should be given in community psychiatric facilities to the treatment of mothers who are experiencing emotional problems, especially when they have young children. Further research should be conducted on the effects of physical and psychological illness of parents on child mental health and ways to minimize whatever adverse effects may be produced. Efforts should be made to provide financial support to families when the father or mother is ill for long periods of time. Homemaker services need to be further developed for use when the mother is physically or psychologically incapacitated,

dies, in some instances of child abuse and in some cases of non-organic failure to thrive in infants.

This Forum recommends an increase in marital counseling services and the setting of standards in this area as an effort to preserve the integrity of families. The Forum urges exploration of new institutional patterns to meet the needs of the one parent family. Efforts should be made to integrate services so that they can be delivered to families as a whole rather than fragmented as they so frequently are today. Families in difficulty should have access to adequate counseling services, including genetic counseling services, when these are needed.

f. Transportation

Both in large cities and isolated rural areas, lack of transportation may be a major barrier to utilization of health services.

2. Developmental Levels

Preventive health services based on the developmental level of the child apply to both normal and handicapped children. There has too often been a reluctance to perceive what is common between handicapped and normal children and the development of separate services for categorical illnesses with the emphasis chiefly placed upon a specific defect rather than the total development of a child or the adjustment of the family. This often happens even though the multidisciplinary team aspires to comprehensive care. It may be necessary, therefore, to complement the traditional multidisciplinary categorical disease clinics with settings in which children are seen according to their developmental stage rather than their disease

state. Such an approach would promote management attuned to the development of the child and include attention to the family as well as the child without reducing the effectiveness of special services for categorical illnesses when needed.

Because of the special hazards to health and the changing opportunities for health enhancement at various stages of human development, this Forum believes that organizations of preventive health services can profitably be approached on the basis of developmental stages as exemplified by the following comments.

a. Prenatal

The goals for adequate prenatal services have been stressed above. Fuller use should be made of educational opportunities to help mothers and fathers during the prenatal and perinatal periods, especially new parents. Mothers who are at high risk because of either organic or psychologic reasons should receive special attention. They and their babies represent a specially vulnerable group.

More adequate support services are needed for mothers during the prenatal period. Special attention should be given to maternity benefits. Most advanced countries except the United States give special recognition to women who are pregnant and provide appropriate adjustment in their working life. Such benefits could include a maternity leave of absence, time off to visit their physician for prenatal examinations and other considerations necessary to protect the health of the mother and developing infant.

b. Perinatal

National standards should be developed for perinatal care

including standards for newborn intensive care units. Hospitals unable to meet such standards should be required to close their obstetrical and neonatal services and should be provided funds to remodel this space for other uses.

Support should be given for the development of transportation of babies born in outlying hospitals to regional perinatal centers when special help is required.

Because the birth of a premature infant and the subsequent physical separation of the mother from the infant may interfere with the development of a close relationship between mother and infant, consideration should be given to changing current policies which restrict access of the mother to the infant.

The lying-in period provides an opportunity to help identify problems, e.g. whether adequate arrangements have been made for the mother and infant's return home, to discuss infant care, and to provide information about family planning. The mother who wishes to breast feed her baby should be provided assistance and encouragement. Health services, particularly supportive services, for mothers should be augmented during the early weeks after birth with home visits by professional staff or health aides.

Greater attention should be given to education of women in mothercraft. Communities should have well-organized arrangements for answering parent's questions.

c. Infancy

Failure to thrive involves many thousands of infants in this country. A major effort should be made for the prevention of this symptom complex or for early intervention. Most instances of failure to thrive are due to a mothering disability.

Understimulation or inappropriate stimulation presents a developmental threat to thousands of infants.

A national effort should be made to immunize every child in this nation.

This Forum supports the establishment of day care centers for infants and preschool children throughout the nation. Such centers have the potential for fostering physical, social, cognitive and emotional development. They should provide a setting which is physically safe and sanitary, good nutrition, warm caretakers to mother the children, activities which are stimulating and enjoyable, opportunities for play and for the use of the young child's sensory and motor functions and a chance to be happy. A guide to standards for day care of children under three years of age has been prepared by the American Academy of Pediatrics Committee on Infant and Preschool Child.

Day care centers are not, however, a panacea. They cannot compensate adequately for inadequate mothering or be a substitute for more continuing stimulation within the home. Programs in which child development aides visit the child's home and work with the mother to provide a more growth-promoting environment for the infant need further explorations.

In addition to day care centers, the community should have drop-in child care centers where infants or young children can be left safely when the mother has a sudden emergency in the family or when she has to take other children or herself for medical care or other appointments.

d. Early Childhood

This Forum gives its warm endorsement to the Head Start

program and recommends that it be extended to all children in this nation on a year-round basis.

The Forum also wishes to express its great concern about the prevention of accidents to children and urges operational research for the prevention of such accidents.

This Forum believes that hospitalization of children should be prevented whenever possible by greater development of ambulatory care facilities, day care, home care programs, parent-care motel-like units in children's hospitals and arrangements for mothers to live in with the child patient. Increased preparation of children for hospitalization or for surgery needs emphasis. Greater attention should be given to the needs of children as children in hospitals. The development of hospital child life workers whose chief emphasis is on the provision of such needs needs further exploration.

Day care nursery schools need to be further developed for young handicapped children as well as for non-handicapped children. Frequently the handicapped child can be included in nursery schools for non-handicapped children.

e. School

Educational opportunities, inadequate in many areas for children with normal intellectual development, are often tragically underdeveloped for children with specific learning disabilities, mental retardation, emotional disturbance or other handicapping conditions. Educational opportunities for the nation's gifted children are underdeveloped. The teachers can provide for every child an important figure with which to identify, thus promoting the child's motivation to learn and creating or reenforcing an

expectation of personal success.

School health programs should contribute to the development of life-long patterns of physical activity and fitness. Health instruction, including family life education, sex education, and mental health should help the child know more about himself and his family and should instill a sense of personal responsibility for his own health.

In some cases the school may have to function as a parent-surrogate for health services for children of school age.

Teachers should have easy access to early consultation with psychologists, social workers, pediatricians and child psychiatrists in relation to some of the developmental problems confronting them in the classroom.

f. Adolescence

This Forum recommends that new opportunities be created for adolescents to work with young children in a variety of ways. There is today much more awareness and concern about their fellow men and more responsiveness among many young people. A greater number of young people want to be of service to others.

There should be a national program with incentives to prevent school drop-outs among adolescents. This would include provisions for adequate clothing for school and utilization of the knowledge already available to prevent unwanted pregnancies in adolescent unwed girls.

Health education programs should help prevent the use of cigarettes, alcohol and drugs. Adequate driver education and promotion of highway safety are other important components of a broad educational approach to the adolescent.

g. Adulthood

Information relevant to the prevention of disease in adult life should be implemented.

3. Education of Child Care Workers

This Forum endorses efforts to broaden the knowledge of all child care personnel concerning child growth and development and to increase their sensitivity to the needs of children. Not only will this enhance their services to children but it will also promote early detection of aberrations in normal development and permit early assessment and intervention.

4. Protective Services

a. Child Abuse

This Forum recommends that the National Conference of Commissioners on Uniform State Laws draft an uniform child abuse act, that state-wide central registries be maintained of reported information of child abuse, i.e., age and sex of the child, type of abuse, identity, relationship to child if any, and other characteristics of the child abuser.

b. Protective Housing

This Forum recommends that a protective housing act be passed by Congress, providing funds for the establishment of children's homes or children's villages in local communities adequate to meet the needs of neglected, abused and dependent children. The protective home should not be an institutional one nor the traditional foster home, but a family type dwelling built by federal funds and staffed by professional house parents under the supervision of the State Department of Welfare. Several such homes may comprise a children's village. Children's homes

of this type would provide a warm, home-like atmosphere and family setting lacking in institutions and would provide an adequate standard of care too often lacking in foster homes. Moreover, protective homes of this type would provide the security which comes from continuous living in one home as contrasted to the insecurity engendered by living in a succession of foster homes. These homes could accommodate all siblings of a large family where necessary and thereby maintain security and sibling solidarity which is destroyed when siblings are distributed among several foster homes. They would also provide facilities for the protection of the hard-to-place child, especially the adolescent girl, who often is a victim of incest or who runs away because of parental sexual molestation.

Placement is essential in the case of abandoned, deserted, starved, battered, or sexually abused children. It is often indicated *in communities* of children whose homes are so deprived and whose parents so disturbed that the total living environment is unfit and not conducive to physical, mental and social well-being.

c. Institutionalized Children

This Forum strongly urges the appointment of a Presidential Commission to examine the adequacy of services for institutionalized children and to investigate reports of maltreatment and low standards of child care.

d. Adoption

Many deficiencies remain in the area of adoption. Public agencies responsible for adoptive placements in many states are greatly underdeveloped. Standards vary widely. There remains an

insufficient number of adoptive homes, especially for babies of minority groups and for handicapped infants.

e. Foster Care

Foster care services are often inadequate. Emotional problems frequently ensue or are accentuated because children are placed in inadequate homes and moved frequently. Siblings are frequently separated. This is an important area for action with greater effort to find suitable foster homes, compensating foster parents adequately and exploring other institutional models as discussed above.

5. Child Advocacy

This Forum recommends the development of a national, state and community child advocacy system to delineate the needs of children of families, to promote solutions, to authorize studies, to hold hearings and to promote the goal of healthy children and healthy families.

This Forum believes that children's needs need to be made highly visible; otherwise, experience has shown that children and youth do not receive appropriate attention or support. Children need a lobby.

This Forum also recognizes that coupled with an advocacy system, there is need for a detailed, realistic program for child health with a variety of options and an indication of priorities. Advocacy without plan or a real chance to do something about the needs and problems identified leads only to frustration.

A form of advocacy could be developed through the appointment of community child health specialists. This person, who would have generic training in pediatrics and a background similar to that of maternal and child health officers, would be a member of the

municipal health and welfare council or similar organizations now functioning in most metropolitan communities to develop optimal community services on a broad front. The pediatrician functioning as the community child health specialist would represent children's needs in the community. He would utilize the assistance of resource people in his own department as well as practitioners in the community and the various voluntary health and welfare agencies in an effort to advance comprehensive child care at the community level just as the pediatric practitioner does this at the family level.

Community services could be greatly strengthened and advanced if persons with the biological and social background, the special proficiencies and capabilities of the pediatrician, would become increasingly involved in the child welfare field. The contribution that an individual pediatrician or other child care professional can make to the mental and physical health of children is impressive, but it is as nothing compared to the contribution that will come with the eventual strengthening of community resources.

6. Research

This Forum supports the need for further research related to child growth and development.

C. Comprehensive, Family-Centered Care

1. Neighborhood Human Service Centers

This Forum recommends the establishment of neighborhood human service centers as a new kind of institution to meet the basic needs of children, youth and families. There is an urgent need for a reinstitutionalization and reconstruction of systems for delivering human services in settlements throughout the nation.

Such organizations would be pleuralistic rather than mono-

lithic and democratic rather than proprietary. They would represent an administrative and operational blend of governmental, voluntary and private enterprise; pediatric and family care; and therapeutic, rehabilitative, preventive and developmental health services. The units would provide for each child and family in this country a clearly established entry to family services including health services. They would function as operational units through which services could be effectively funneled into neighborhoods. Focused on the needs of both individuals and populations in both health and disease, they would attempt to consummatethe marriage of public health and clinical pediatrics. Through epidemiological approaches and other monitoring of the needs of children and youth in the neighborhood and continuing appraisal of programatic effectiveness, they would remain responsive to the needs of the time

In recommending such a comprehensive neighborhood human service center, the Forum accepts the following notions:

a. The needs of the child cannot be separated from the needs of his family and his neighborhood.

b. Public services such as health, welfare, and education need to be integrated in many situations. There are too frequent referrals of persons from agency to agency, too many repetitive interviews and too much variation in eligibility for services. Duplication of interviews, records and follow-up services are wasteful of time, money and scarce social resources. Non-sensitive material such as immunization data could be stored in a data bank.

c. The present delivery systems for family or children services are neither comprehensive nor efficient. Families should receive

attention as a unit.

d. The possibilities of new kinds of partnerships between voluntary and public agencies warrant further exploration.

e. There is a pressing need for new kinds of supportive family services at the block and neighborhood levels. Service units should be convenient to the clients, hopefully within walking distance. Since social, health and other services are not always accessible to people who live in neighborhoods, such services should be decentralized.

f. There is a need for the professionalization of child development workers.

g. The large, unused, reservoir of underdeveloped talent among men and women in our community could be utilized for augmented human services. Additional work-study programs which lead to appropriate certification and opportunities for upward mobility are needed.

h. Services must be organized to meet the needs of individuals and families who present with multiple problems.

i. The development of neighborhood services should include consumer participation. Such participation in all stages of planning and implementation would help earn their trust, achieve a balance between the recommendations of the professional and the wishes of the consumer, and promote utilization.

j. There would be an active program of reaching out to the consumer, patient pursuit and follow-through. Special attention would also be assigned to families who because of their disorganization do not or cannot utilize services even when there are no external barriers.

Because the individual service units would be tailored to the needs of particular communities, they would be responsive to the needs and wishes of the residents concerned. By providing increased understanding, a friendly reception, assistance in transportation and availability of baby-sitting service, the units would help decrease barriers to the utilization of health and social services.

The neighborhood human service center could be directed by a new kind of quasi-public agency charged with the integration of the services of existing public and voluntary agencies in a specific neighborhood and the development of new programs.

While the neighborhood service unit could be physically located in one site as a human service park or department store, its central core could be located adjacent to a school, community center, or housing project with direct contractual ties to a network of other services and facilities in that neighborhood or elsewhere in the city.

The staffing of the neighborhood human services center would include an administrator, a planning and evaluation section, an information center, and a group of paraprofessionals who would have a kinsman-like relationship to the individuals and families in the neighborhood. These kinsman-like individuals would be specially trained to serve as representatives and advocates for the families and individuals in the neighborhood. Block workers, appointed to help individuals living in individual blocks, would offer support to families in their block, know who moved in and who moved out, assist the school in health education, urge families to make adequate utilization of health services

and foster pride in their block.

In addition to these new kinds of positions, various metropolitan voluntary agencies, e.g. the Family Service Agency would establish branch offices in the neighborhood human service centers. If professional social work services were thus made available in the neighborhood, the great demand made upon school social workers might be lessened or their efforts made more effective. In addition to such full-time persons, there would be circuit-riding specialists from central agencies, e.g. legal aid personnel moving from center to center to hold office hours in neighborhood service units once a week. Metropolitan public agencies would also assign full-time personnel to the neighborhood human service centers while keeping professional and administrative ties to their central department. Examples would include public health nurses, welfare workers, and employment counselors. Circuit riders in public agencies would include probationary officers and housing counselors.

The neighborhood human service center would thus have the administrative charge to develop in its neighborhood, with the help of appropriate public and voluntary agencies, those programs essential for adequate family and children services, e.g. early childhood centers, reading centers, middle schools, vocational and adult education programs, parent education, special education, health centers, resources for handicapped children, social services, legal aid, employment assistance, day care center, protective housing, housing and recreational facilities. Adolescent activity clubs, a 24-hour information source and a homemaker pool would also be included.

These neighborhood service centers would be allied with a central department of family and human services, a quasi-public corporation or some other administrative arrangement as determined by the specific community. This central unit would have a director, an information center, a section for planning and evaluation and professionals responsible for supervision of the kinsman-like aides who work in the neighborhood human service centers. This section of supervisory professionals would include family workers, child development specialists and persons knowledgeable about adolescents under the direction of the community child health specialist described above.

The neighborhood human service center, family, developmentally, and health rather than disease-oriented, would serve as the setting for health screening, early detection and preventive care as well as for treatment of minor illness or injury. They would be open weekends and evenings as needed. Family planning services and prenatal care would also be offered. Treatment, remediation, prevention and health enhancement would be accomplished as appropriate during each contact. Contractual arrangements would exist for referral as needed of patients and/or consumers to other regional community services such as hospitals.

In attempting to provide a new kind of quasi-familial institution and in offering a kinsman-like relationship, the human service center would provide a new approach to the socially isolated and the alienated and would replace, to some extent, the extended family and neighborhood supports of the past. It might also contribute to the recreation and reconstruction of

neighborhoods. Families indeed need a readily accessible and reliable place to turn in the time of crisis or acute need, but they require equally the comfort and belief there is someone or some group whom they can trust, a program which has the capability in terms of staff committed to the value of human beings, and the facilities to help them deal with life's daily problems.

The neighborhood human service center would represent a positive and preventive approach to child health in contrast to the ameliorative, remedial or therapeutic approach so characteristic of most of our health and welfare services of today. Such centers could help develop a true health alliance between the consumer and the provider by helping eliminate fear and establish genuine communication. They would help to teach the consumer the things he needs to know to protect his own well-being and that of his children.

These centers would not be restricted to poverty areas, although they are most needed there. They eventually could be developed in all neighborhoods to make readily available those adjunct resources required by today's pediatrician who wishes to deliver comprehensive, family-centered, developmentally-oriented child care.

2. Integration of Financing and Administration

There is a pressing need for integration at many levels.

a. Unifying of health planning.

b. Unifying of public program administration.

c. Unifying of financing.

Although programs for children and families may have multiple funding sources there should be some mechanism to combine these financial supports, eliminating the fragmentation caused by categorical health programs and the separation between wellness and illness care.

There are, for example, a number of well-conceived, federally sponsored educational programs, with significant health inputs, that span the totality of infancy through childhood. The programs are: (1) Parent and Child Care Centers (P.C.C.) - 0-3 years; (2) Head Start (H.S.) - 3-6 years; (3) Follow Through (F.T.) - K-3rd Grade; (4) Title I Program (Elementary - J.H.S. particularly) and (5) rapidly proliferating Day Care Programs under a variety of auspices. If each of these programs existed in the same community, as logically they should, there could be an uninterrupted sequential movement of the child through each program terminating in a maximally beneficial outcome.

The fact is, however, that each of these programs is individually administered, located and evaluated with little regard to the local situation. The incredible fragmentation and lack of communication at the national level is reflected also at the regional, state and local levels. Although each of these programs have well-developed health components, they vary as to basic objectives and as to the methodology of achieving these objectives. To complicate the health picture even more, add to this the multiple health programs also concerned with this same population. Integration of such programs as maternal and infant care projects,

children and youth programs and neighborhood health centers needs to be pursued further.

Prepared by Morris Green, M. D.

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